# Tennessee Department of Health
# STATE LOAN REPAYMENT PROGRAM

## Application
## for
## Primary Care

## Advance Practice Nurses
## Physician Assistants

**Certified Nurse Practitioners**
**Certified Nurse Midwives**
**Certified Physician Assistants**

*Please be advised that loan repayment awards are contingent upon approval by the Commissioner or designee, Tennessee Department of Health, and available funding.*

# Tennessee Department of Health
# State Loan Repayment

***Only qualifying Public or Non-Profit Private ambulatory primary care entities, located in a federally designated Health Professional Shortage Area (HPSA) are eligible practice sites for participation in TSLRP.**

Is this site***** ☐ Public ☐ Non-Profit Private Please provide 501(c) (3) ☐ For-Profit Private (**Stop Completing Application**)

Do you have a Primary Care Loan? If yes, (**Stop Completing Application**)

*Please type or print in ink. If you need additional space for any of the questions, please attach additional sheets.*

## Section I

**1. Applicant Identifying Information**

Name: _____ Last _____ First _____ Middle

List below any previous names used, especially if loans were made under those names:

_____ Last _____ First _____ Middle

_____ Last _____ First _____ Middle

**Current Home Address:** Enter your address including street number, name, and apartment number (if applicable). Use the two-digit postal service code for state. This is the address we will use as your mailing address.

Address: _____

_____

City: _____ State: _____ Zip: _____

Home Phone Number: _____ - _____ - _____

Cell Phone Number: _____ - _____ - _____

E-mail Address: _____

☐ Are you an employee of the State of Tennessee? or ☐ Are you a County employee?

**Current Work/School Address:** Enter the address where you can be reached during working hours.

Address:

_____

_____

City: _____ State: _____ Zip: _____

Work/School Phone Number: - -

Social Security Number - -

**2. Type of Specialty:** _____

**3. Birth/Citizenship Information**

*Birth Date: _____ City: _____ County: _____ State: _____

Gender: ☐ Male ☐ Female

U.S. Citizens or nationals are eligible for this program. Are you a citizen or national of the United States?
☐ Yes ☐ No

*Note: If you are foreign-born, please submit evidence of your U.S. Citizenship with application.*

*** Federal reporting guidelines requires age and race information.**

***Race/Ethnicity**
☐ Hispanic
☐ American Indian, Eskimo, or Aleut (AIEA)
☐ White (except Hispanic)
☐ Asian or Pacific Islander (API)
☐ Black (except Hispanic)
☐ Other: _____

**4. Language Skills:** Please indicate below any languages other than English which you can read, write or speak.

Language: _____ Read: ☐ Write: ☐ Speak: ☐

Language: _____ Read: ☐ Write: ☐ Speak: ☐

Language: _____ Read: ☐ Write: ☐ Speak: ☐

**5. Existing Service Obligation:** Please check yes or no to indicate whether or not you have an existing service obligation. If you check yes, please complete the rest of the items in this section concerning that obligation. If you have no existing service obligation, please check no and go to number 6.

**Do you have an existing contract or service obligation?**
(i.e., National Health Service Corps, Underserved Clinical Scholars Program, Nurse Education Loan Repayment, Nursing, or other Scholarship obligation, Active or Reserve Military obligation, outstanding contractual obligation for Health Professional services to the Federal Government, or any non-government obligation, etc.)?

☐ Yes ☐ No

Program Name: _____

Program Address: _____

_____

City: _____ State: _____ Zip: _____

Contact Person: _____

Phone Number: _____ - _____ - _____

Please describe the terms of your contract or service obligation, including base salary, incentives, etc.

Are you in default of this obligation? ☐ Yes ☐ No

Date obligation completed or to be completed: _____

6. **Date Available for Program:** Enter the date you will be available to begin practice. You must have completed your training and acquired the appropriate license in order to practice your profession in the state of Tennessee, by this date.

Date Available: _____

7. **Personal Considerations:** Please describe below any personal considerations concerning you or your family that would affect your ability to serve in any specific area of Tennessee. Such considerations might include: spouse employment options, preferences for particular types of communities (urban, rural areas with special health problems) or specific communities, type of practice, or any other concerns or preferences you have.

8. **Practice Site**

If you have already identified a practice site, please indicate below:

Name of Practice Site: _____

Address: _____

City: _____ State: _____ Zip: _____ County: _____

Program Director: _____

Phone Number: _____ - _____ - _____

Is this site an Ambulatory Clinic setting? ☐ Yes ☐ No

When will you begin or when did you begin practicing at this site? _____

How many *hours per week* will you practice **direct patient care** at this site? ** _____

Does the site provide primary care services to any of the following patients? Check all that apply:

☐ Medicaid ☐ Medicare ☐ SCHIP (CoverKids) ☐ Uninsured or Low Income on a Discount Sliding Fee Scale?

***Note:** The State Loan Repayment Program Federal Guidelines **requires** all practitioners to work a minimum of forty (40) hours per week, with a minimum of thirty-two (32) hours devoted to direct patient care except OB/GYN Physicians, Family Practice Physicians that provide these services the majority of time and CNMs who are required to provide a minimum of twenty-one (21) hours of direct patient care out of the minimum forty (40) hours per week.*

Are you employed by the site identified above? ☐ Yes ☐ No

Are you employed by another entity?* ☐ Yes ☐ No

If yes, please identify the entity, provide a contact name, and contact person's phone number below:

Is this entity ☐ Public ☐ Non-Profit Private ☐ For-Profit Private

Have you included a 501(c) (3) with this application (Stop Completing Application)

Name of Employing Entity*: _____

Contact Person: _____

Phone Number: _____ - _____ - _____

## Section II

**Educational and Practice Experience**
For Graduates Only

**1.** **Undergraduate Schools:** Please list the name(s) and address(es) of the undergraduate school(s) from which you graduated, including the degree(s) earned and the graduation year(s). List additional undergraduate schools on a separate attachment, if applicable.

School Name: _____

Address: _____

_____

City: _____ State: _____ Zip: _____

Degree Earned: _____ Graduation Date: _____

**2.** **Professional Schools:** Please list the name(s) and address(es) of the professional school(s) from which you graduated, including the degree(s) earned and the graduation year(s). List additional professional schools on a separate attachment, if applicable.

School Name: _____

Address: _____

_____

City: _____ State: _____ Zip: _____

Degree Earned: _____ Graduation Date: _____

School Name: _____

Address: _____

_____

City: _____ State: _____ Zip: _____

Degree Earned: _____ Graduation Date: _____

**3.** **Graduate Program Information:** Please enter information pertaining to the graduate program you have completed or are in the process of completing.

**FOR NURSE PRACTITIONERS ONLY:**

Have you completed a graduate program? ☐ No ☐ Yes Masters Degree Earned: _____

If No, are you currently in the process of completing a graduate program?

☐ No (Explain in the section below): ☐ Yes Anticipated Graduation Date: _____

_____

_____

Graduate Program Name: _____

Start Date: _____ Graduation Date: _____

Address: _____

_____

City: _____ State: _____ Zip: _____

Program Director: _____

Director's Phone Number: _____ - _____ - _____

**FOR PHYSICIAN ASSISTANTS ONLY:**

Have you completed a PA Program? ☐ No ☐ Yes Degree Earned: _____

If No, are you currently in the process of completing a PA Program?

☐ No (Explain in the section below) ☐ Yes Anticipated Graduation Date: _____

_____

_____

Graduate Program Name: _____

Start Date: _____ Graduation Date: _____

Address: _____

_____

City: _____ State: _____ Zip: _____

Program Director: _____

Director's Phone Number: _____ - _____ - _____

Indicate Board Certifications or Eligibilities, recertification years (if applicable) and subspecialties (if applicable).

| Eligible or Certified | | Board | Year | Subspecialty |
|---|---|---|---|---|
| ☐ | ☐ | _____ | _____ | _____ |
| ☐ | ☐ | _____ | _____ | _____ |
| ☐ | ☐ | _____ | _____ | _____ |

4. **Program Training Experience:** Describe program experiences you have had outside of teaching hospitals or institutions. Include any experiences involving clinical practice or rotations in urban or rural shortage areas and the nature and length of those experiences.

_____

_____

_____

_____

_____

_____

_____

5. **Credentials:** List all licenses, registrations, and/or certifications ever held, medical or other, including the state(s), dates, received, and any license restrictions. If you have none of these credentials, please indicate the status of the examination(s) you have taken or plan to take, the dates(s) taken or scheduled, and the state(s) in which the examination(s) will be taken.

| **License Number** | **State** | **Date Received** | **Expiration Date** |
|---|---|---|---|
| _____ | _____ | _____ | _____ |

Describe any restrictions on the above: _____

_____

| **Other Credentials** | **State** | **Date Received** | **Expiration Date** |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Describe any restrictions on the credentials listed: _____

_____

| **Examinations** | **Passed** | | **Plan to Take** | | **State** |
|---|---|---|---|---|---|
| | Month | Year | Month | Year | |
| State or Regional Board | _____ / | _____ | _____ / | _____ | _____ |
| National Certification | _____ / | _____ | _____ / | _____ | _____ |
| Other: _____ | _____ / | _____ | _____ / | _____ | _____ |

If NP, do you have your certificate of fitness? ☐ Yes ☐ No

If No, please explain: _____

Precepting Physician: _____

Specialty: _____

**6. Professional Training Location(s):** List all training sites or locations of your graduate professional training, including hospitals, clinics, and service centers.

Practice Site: _____

Address: _____

_____

City: _____ State: _____ Zip: _____

Director's Name: _____

Director's Phone Number: _____ - _____ - _____

Practice Site: _____

Address: _____

_____

City: _____ State: _____ Zip: _____

Director's Name: _____

Director's Phone Number: _____ - _____ - _____

Practice Site: _____

Address: _____

_____

City: _____ State: _____ Zip: _____

Director's Name: _____

Director's Phone Number: _____ - _____ - _____

7. **Practice Experience:** Describe any practice experience over the last five (5) years. Include location(s), nature of the population(s) served, number and specialties in the practice, hospital affiliations, and allocation of practice time to FP/ GP, IM, OB/GYN, PED. Indicate any practice in rural or urban areas with a substantial number of indigent patients or patients with severe health problems.

_____

_____

_____

_____

_____

_____

_____

_____

_____

8. **Site Director:** Please list the name, address, and phone number of the site director or official at the last site which you practiced or worked as a clinician.

Director's Name: _____

Address: _____

_____

City: _____ State: _____ Zip: _____

Director's Phone Number: _____ - _____ - _____

9. **Percent of Practice Time:** Indicate the percent of time your practice was devoted to the categories listed. If a substantial percent of your time was spent in a category not listed, use the "Other" category and identify the activity.

Office Based: _____ % Hospital Based: _____ %

Teaching: _____ % Administration: _____ %

Other: _____ %

**10.** **Professional Reference Information:** Complete the information below for three (3) individuals who have knowledge of your professional qualifications and competence.

Name: _____

Title or Position: _____

Address: _____

_____

City: _____ State: _____ Zip: _____

Phone Number: _____ - _____ - _____

Name: _____

Title or Position: _____

Address: _____

_____

City: _____ State: _____ Zip: _____

Phone Number: _____ - _____ - _____

Name: _____

Title or Position: _____

Address: _____

_____

City: _____ State: _____ Zip: _____

Phone Number: _____ - _____ - _____

**11.** **Commitment to Serve in a Health Professional Shortage Area (HPSA):** Participants are required to complete an initial two (2) year service commitment. Eligible participants may reapply after fulfilling the initial two (2) years of service for one (1) year amendments as long as they are in good standing and still have outstanding educational loans to repay. The total maximum service commitment is five (5) years.

What length of time are you willing to commit to practicing in a Health Professional Shortage Area?

☐ 2 years ☐ 3 years ☐ 4 years ☐ 5 years

**Section III**

**Additional Information and Application Certification**

Have you ever been arrested or convicted for any criminal offense, to include a misdemeanor or a felony?

☐ Yes ☐ No

If yes, please complete the following information:

Offense: _____

When: _____

Where: _____

Disposition: _____

Have you ever been in a drug treatment program? ☐ Yes ☐ No

Have you ever been in an alcohol treatment program? ☐ Yes ☐ No

Do you have any criminal lawsuits pending? ☐ Yes ☐ No

Do you have any criminal judgements outstanding? ☐ Yes ☐ No

Do you have any outstanding contractual obligation for health professional services to the Federal Government (i.e. active duty military obligation, NHSC LRP, NHSC Scholarship Program obligation, NELRP or Nursing Scholarship Program obligation or to a State or other entity)? ☐ Yes ☐ No

Have you been delinquent in child support payments? ☐ Yes ☐ No

Do you have a judgement lien against your property for a debt to the United States? ☐ Yes ☐ No

Have you defaulted on any Federal payment obligations (e.g., Health Education Assistance Loans, Nursing Student Loans, Federal income tax liabilities, FHA loans, etc.) even if the creditor now considers you to be in good standing? ☐ Yes ☐ No

Have you breached a prior service obligation to the Federal/State/local government or other entity, even if you subsequently satisfied the obligation? ☐ Yes ☐ No

Have you had any federal debt written off as non-collectible? ☐ Yes ☐ No

Have you had any federal service or payment obligation waived? ☐ Yes ☐ No

Have you ever been disciplined by a State Health Regulatory/Licensing Board? ☐ Yes ☐ No

If yes, please complete the following information:

Violation: _____

When: _____

Where: _____

Action: _____

_____

Have you ever been excluded from participating in Title XVIII or any other state health care program?

☐ Yes ☐ No

If Yes, please complete the following information:

Program: _____

When: _____

Where: _____

Action: _____

_____

**OUTSTANDING EDUCATIONAL LOAN BALANCE**

A qualifying educational loan is a Government and commercial loan for actual cost paid for tuition, reasonable educational and living expenses related to the undergraduate or graduate education of the participant leading to a degree in the health profession in which the participant will satisfy his or her SLRP service commitment. Applicants must provide a copy of all qualifying loan documentation (e.g., promissory notes).

If an applicant has **consolidated loans or refinanced loans,** the applicant must provide a copy of the original loan documentation to establish the educational purpose and contemporaneous nature of such loans. If an eligible educational loan is consolidated or refinanced with any other debt other than another eligible educational loan of the applicant, no portion of the consolidated or refinanced loan will be eligible for loan repayment.

Complete the information below concerning any outstanding educational loans that meet the above definition.

| Type of Loan | Lending Entity | Institution Attending at Time of Receipt | Date Approved | Balance Due |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

## PLEASE MAIL THE COMPLETED APPLICATION TO:

**Tennessee Department of Health**
**Office of Rural Health**
**Attn: Tresea Donelson**
**710 James Robertson Parkway**
**Andrew Johnson Tower, 2nd Floor**
**Nashville, TN 37243**

# TENNESSEE STATE LOAN REPAYMENT PROGRAM REQUIREMENTS

***Recipients of a State Loan Repayment Program award must comply, at minimum, with the following requirements:***

Any applicant approved for receipt of a Grant Award shall be required to enter into a contract with the Tennessee Department of Health to include, but not limited, to all the requirements indicated below.

Perform service obligation by providing primary health care and clinical practice on a full-time basis in a public or nonprofit private entity located in a current federally designated Primary Care Health Professional Shortage Area (HPSA).

Work full-time with at least thirty-two (32) of the minimum forty (40) hours per week providing direct patient care.
EXCEPTION: OB/GYN physicians, family practice physicians who practice obstetrics on a regular basis and certified nurse midwives provide at least twenty-one (21) of the minimum forty (40) hours per week spent providing direct patient care. Hours remaining outside of the minimum for direct patient care will be spent providing inpatient care to patients of the approved site and/ or practice related administrative activities. Time spent "on call" does not count toward the minimum forty (40) hour per week requirement.

Charge for professional services at the usual customary prevailing rate or on a reduced rate or at no charge if a patient is unable to pay.

Agree to provide primary health services to any individual seeking care and not discriminate on the basis of the patient's ability to pay or on the basis that payment will be made pursuant to Medicare (established in Title XVIII of the Social Security Act), or Medicaid (Title XIX of such Act), or the State Children's Health Insurance Program (Title XXI of such Act).

Agree to accept assignment under Medicare (section 1842 (b) (3) (B) (ii) of the Social Security Act) for all services for which payment may be made under Part B of Title XVIII; and enter into an appropriate agreement with the State agency that administers the State plan for Medicaid under Title XIX to provide services to individuals entitled to medical assistance under the plan; and enter into an appropriate agreement with the State Children's Insurance Program (SCHIP) or Cover Kids to provide services to children under Title XXI.

Use the State Loan Repayment Program funds to repay qualifying education loans, only. (Funds are not to be used as a salary offset.)

Repay funds as a result of default or breach in service commitment at a rate that shall be determined as follows: The portion of the State Loan Repayment Award which equals the sum of the period of obligated service not served **AND** $7,500 multiplied by the number of months of obligated service not served **AND** interest on the total amount.

**WARNING**
Any person who knowingly makes a false statement or misrepresentation in this application, bribes or attempts to bribe a state official, fraudulently obtains repayment for a loan under this statute, or commits any other criminal action in connection with this application is subject to a fine or imprisonment under Tennessee Code Annotated, Title 39, Chapters 14 and 16 and any other applicable state law.

Recipients of Federal funds are subject to the strictures of the Medicare and Medicaid anti-kickback statute (42 U.S.C. 1320a - 7b (b) and should be cognizant of the risk of criminal and administrative liability under this statute, specifically under 42 U.S.C. 1320 7b(b) Illegal remunerations.

**CERTIFICATION**
Read the statement below and sign your full name in ink and date the signature to indicate that you agree with the contents of the statement.

**I have read the above warning statement and understand its contents. I certify that the information given in this application is accurate and complete to the best of my knowledge and belief. I understand that it may be investigated and that any willfully false representation is sufficient cause for rejection of this application, or, if awarded a grant, that I am liable for repayment of all awarded funds.**

_____ _____

Signature Date

_____

Print Name